State of California-Health and Human Services Agency
Department of Health Care Services

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Director

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Home- and Community-Based Services (HCBS) Waiver Application

⇒ *Para recibir esta información en español, por favór llámenos a uno de los números siguientes: (916) 552-9105.*

To apply for one of the Medi-Cal HCBS Waivers administered by the In-Home Operations (IHO) Section, please complete this two-page application.

Applicant's Name: _____ **Home Phone:** (____) _____

Date of Birth: _____ **Age:** _____ **Male** ☐ **Female** ☐ **Married:** Yes ☐ No ☐

County in which the Applicant currently resides: _____

Where is the Applicant currently residing? At home ☐ Hospital ☐

☐ Nursing facility:_____ ☐ Other:_____
Facility Name and City Please specify

Mailing Address: _____ **City:** _____, **CA ZIP:** _____

Street Address: _____ **City:** _____, **CA ZIP:** _____
(If different from Mailing Address)

Medi-Cal? ☐ Yes ☐ No If Yes, Medi-Cal Number:_____
Located on applicant's Medi-Cal Beneficiary Identification Card (BIC)

Medicare? ☐ Yes ☐ No If Yes: ☐ Part A ☐ Part B ☐ Part A & B ☐ Part D

Other Medical Insurance? ☐ Yes ☐ No If Yes, please identify:_____

List <u>current</u> medical diagnoses (main illness or injury):_____

_____

Check the boxes that identify your <u>current</u> medical needs. Use the blank spaces below to write-in your specific medical needs that are not listed. You may provide additional comments on the back of the application.

☐ Ventilator - Hours Used Per Day _____
☐ Continuous Positive Airway Pressure (CPAP) Device - Hours per day:_____
☐ Bi-Level Positive Airway Pressure (BiPAP) Device - Hours per day: _____
☐ Respiratory Treatments -Number per day) _____
☐ Room Air Mist
☐ Oral (by mouth) Medications
☐ Gastric Tube (GT) Medications
☐ Intravenous (IV) Medications
☐ Chronic Pain Treatment
☐ Contractures
☐ Continuous Use of Oxygen
☐ Oral (by mouth) Feedings
☐ Gastric Tube (GT) Feedings
☐ Intravenous (IV) Nutrition
☐ Pressure Sores/Open Wounds
☐ Skin or Wound Treatments
☐ Tracheostomy
☐ Tracheal Suctioning
☐ Oral Suctioning
☐ Nasal Suctioning
☐ Oxygen as needed
☐ Urinary Incontinence
☐ Bladder Catheterizations
☐ Bowel Incontinence
☐ Routine Bowel Care
☐ Urostomy/Colostomy
☐ Some ability to move arms or legs. Needs some help with care needs. Briefly explain on back.
☐ No movement of arms or legs. Needs total help with care needs. Briefly explain on back.
☐ Special equipment needs. (Ex: wheelchair, lift system, ramp) Briefly explain on back.
☐ Other_____

If this application is being submitted for the Applicant:

1. Was he/she or the legal representative notified of this application for the HCBS Waiver? ☐ Yes ☐ No
2. Who has the legal authority to make the applicant's health care decisions?

☐ Applicant ☐ Other: _____ (Name) _____ (Relationship) (____) _____ (Telephone Number)

_____ (____) _____ _____

Print the name and title of person completing the application **Contact Telephone** **Date**

Please identify all of your current providers of service:

☐ **Home Health Agency**: _____ (Agency Name and City) Hours per week: _____

Type of services received: ☐ Attendant Care ☐ Certified Home Health Aide Nursing: ☐ RN ☐ LVN

☐ **In-Home Supportive Services (IHSS)** - Hours Authorized Per Month: _____

- *To obtain IHSS eligibility information, please contact the Applicant's county office and ask for the IHSS Intake services.*

☐ **California Children Services (CCS)** - Please describe the service(s) received:

_____ (List Services:)

☐ **Regional Center**: _____ (Center Name) Service Coordinator: _____ (Name)

☐ **Adult or Pediatric Day Health Care**: _____ (Center Name) Days per week: _____

Attends school outside of the home? ☐ Yes ☐ No If Yes, number of hours/day: _____

Does the school provide medical care services at school? (Ex; nursing, therapy) ☐ Yes ☐ No

☐ **Multipurpose Senior Services Program (MSSP)**

- *MSSP is an Home and Community-based Services waiver benefit for Medi-Cal beneficiaries over the age of 65 that provides general services and nursing support. For information on this program, please call 1-800-510-2020, or go to: www.aging.state.ca.us/html/programs/mssp*

☐ **Hospice**

- *Hospice is a Medicare/Medi-Cal benefit for beneficiaries with a terminal diagnosis. For further information on this benefit, contact the Applicant's physician.*

☐ **Medical Case Management (MCM)**

- *MCM offers short-term medical care services for beneficiaries without other sources of health insurance. For further information, please call 1-916-552-9100.*

☐ **Program of All Inclusive Care for the Elderly (PACE)**

- *PACE is a Medi-Cal benefit that provides all needed preventative, primary, acute, long-term care, social and rehabilitative services through one comprehensive program to eligible seniors, 55 years or older. For further information, please call 1-888-633-7223, or go to www.CalPACE.org.*

☐ **Senior Care Action Network (SCAN)**

- *SCAN Health Plan, as a Medicare Advantage Special Needs Plan, offers health and long-term care services to eligible Medicare/Medi-Cal beneficiaries over the age of 65 years. For further information please call 1-877-452-5898, or go to www.scanhealthplan.com.*

When completed, please return this form to IHO at the address listed below. Should the Applicant relocate, have a significant change in health care needs, or change your/his/her Medi-Cal insurance status, please contact IHO at (916) 552-9105.